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# Codependency Among Nurses: A Rural Urban Comparison

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CODEPENDENCY AMONG NURSES:  
A RURAL URBAN COMPARISON

by

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Bachelor of Science in Nursing, University of Minnesota, 1983

A Thesis

Submitted to the Graduate School

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Master of Science

Grand Forks, North Dakota

May

2000

This thesis, submitted by Nancy Carlson in partial fulfillment of the requirements for the Degree of Master of Science from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

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This thesis meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

Harvey Knell

Dean of the Graduate School

5-2-00

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## TABLE OF CONTENTS

LIST OF TABLES.....	vi
ACKNOWLEDGMENTS.....	vii
ABSTRACT.....	viii
CHAPTER	
I. INTRODUCTION AND REVIEW OF LITERATURE.....	1
Introduction.....	1
Purpose of Study.....	4
Review and Critique of Related Studies.....	4
Codependency.....	5
Professional Codependency.....	13
The Rural Factor.....	20
Codependency and Rural Nurses.....	24
Significance of the Study.....	28
Research Questions.....	31
Theoretical Framework.....	31
Definitions.....	34
Assumptions.....	35
Limitations.....	36

II. METHODOLOGY.....	37
Population.....	37
Sample.....	37
Instrumentation.....	38
Data Analysis.....	40
Protection of Human Subjects.....	42
III. RESULTS.....	43
Sample Description.....	43
Presentation and Analysis of Data.....	48
Research Question 1.....	48
Research Question 2.....	49
Research Question 3.....	51
Other Findings.....	53
IV. CONCLUSIONS AND RECOMMENDATIONS.....	56
Summary.....	56
Discussion/Conclusions.....	58
Recommendations.....	66
V. APPENDICES.....	72
Appendix A: Cover Letter.....	73
Appendix B: Friel Codependency Assessment.....	74
Appendix C: Ward Organizational Scale.....	75
VI. REFERENCES.....	79

## LIST OF TABLES

Table	Page
1 Sample Demographic Characteristics (Nomial).....	44
2 Sample Demographic Characteristics (Ratio).....	45
3 Family Historical Data.....	46
4 Codependency Levels.....	47
5 Ward Organizational Features Scores of all Subjects.....	48
6 Population Density by Codependency Level.....	49
8 Organizational Features by Codependency Level.....	51
7 Summary Table for Analysis of Variance of Organizational Features by Codependency Level.....	50
9 Family Dysfunction by Codependency Level.....	52
10 Summary Table for Analysis of Variance for Family Dysfunction by Codependency Level.....	53
11 Summary Table for Analysis of Variance for Family Dysfunction by Codependency Level for Urban Nurses (n =91).....	54
12 Summary Table for Analysis of Variance for Family Dysfunction by Codependency Level for Rural Nurses (n =97).....	54

Table	Page
13 Summary Table for Analysis of Variance for Organizational Features by Codependency Level for Urban Nurses ( $n = 91$ ).....	54
14 Summary Table for Analysis of Variance for Organizational Features by codependency Level for Rural Nurses ( $n = 97$ ).....	55

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## ABSTRACT

This descriptive study was undertaken to examine the role of environmental work stressors and family-of-origin dysfunction in the genesis of professional codependency and compare rural and urban samples of nurses using those parameters. The nursing literature presents us with two contradictory explanations of the relation between codependency and nursing. Some see it emerge when a nurse's wish to care for others is motivated by attempts to fulfill her or his own unmet needs from dysfunctional family experience. Others see the medical institutional expectation of devotion and self-sacrifice by nurses as a causal factor in codependency. Both interpretations are based on the predication that there is a high prevalence of codependency among nurses. A third factor, population density, specifically highly urban verses highly rural practice, may be tied to codependency in that the nature of rural nursing practice makes it especially difficult to distinguish between personal and professional roles.

Registered nurses ( $n = 202$ ) who work in acute care settings in either rural North Dakota or metropolitan Minneapolis, Minnesota were surveyed to determine their codependency level, the presence of family traits associated with codependency and characteristics of their workplace. The Friel Codependency

Assessment Inventory provided a tool to place subjects in categories of codependency from "few codependency concerns" to "severe codependency". Perceived workplace stress was evaluated by the modified Ward Organizational Features scale which rates perceptions of environmental factors which may be stressful to the individual in the areas of professional practice, professional relationships and nursing unit management. Five questions about the subject's childhood family life which have been previously linked to codependency provided data regarding family dysfunction.

Using the Chi-square test, no statistically significant differences were found when the rural and urban samples were compared to the codependency categories. An Analysis of Variance revealed that there also was not a statistically significant relationship between codependency and family-of-origin dysfunction. When the codependency categories were compared to the mean organizational features scores however, an Analysis of Variance revealed that those subjects with few to mild codependency concerns had less perceived workplace stress than those with severe codependency.

The findings of this study did not support the view that children from dysfunctional families seek careers in nursing to meet their codependent needs for self-esteem, control or belonging. Instead, its findings indicate that structural and environmental factors of the modern healthcare workplace such as understaffing, lowering standards to meet financial agendas and multiple regulations may be antecedent to the development of codependent behavior in



individual nurses. This finding is consistent with the general propositions of Field Theory where energy is present in a system and is used to exert influence, disequilibrium or polarization within conscious or subconscious environment.

To Dave, Christopher and Shelby

# CHAPTER I

## INTRODUCTION AND REVIEW OF LITERATURE

### Introduction

The concept of codependency emerged in the mid-1980s from the study of the families of alcoholics. Confusion and conflict marked the early study of codependency, with many different theories and definitions contending for acceptance. Many individuals use the term as it was used in the 1980s to refer to an unhealthy pattern of coping that developed in reaction to a substance-addicted family member (Cermak, 1986). Today, the term is also used in a much broader way to describe phenomena that may occur in relationships where dependency and control are issues (Zerwekh & Micheals, 1989). As researchers and clinicians began to explore codependency, they found it was more common among people with certain histories: adult children of alcoholics; parents of children with behavior problems; people in relationships with chronically ill, emotionally or mentally disturbed, or irresponsible individuals; and those in the helping professions, including nurses (Yates & McDaniel, 1994).

It has been suggested that many people are drawn to the helping professions because these careers perpetuate the roles they played in dysfunctional families. In dysfunctional families, children learn to judge

themselves harshly, fear conflict, feel guilty about taking care of themselves and hide feelings. They become comfortable with chaos, reactionary, controlling and have an overdeveloped sense of responsibility (Arnold, 1990). Researchers believe that codependency can affect not only individuals, but families, businesses, and institutions (Arnold, 1990; Snow & Willard, 1985; Whitfield, 1991). Health care institutions can be as dysfunctional as families and act as the dependent in professional relationships. Patients, physicians and competitive institutional systems expect sacrifice for their own needs. As in dysfunctional families, everyone is expected to become externally focused. In hospitals nurses frequently receive more rewards for focusing on the dependents rather than themselves.

Codependent behaviors of nurses frequently exist to promote a compromise between professional and personal needs. For example, codependent family roles recurrently cited in the literature can be deduced to describe three commonly internalized codependent nursing roles: (a) martyr (one who continually tolerates great inconvenience); (b) persecutor (one who routinely blames others for one's own misery); and (c) enabler (a rescuer who is unable to set limits on personal resources such as time and energy) (Berry, 1988; Sherman, Cardea, Gaskill, & Concetta, 1989).

The predisposition of professional nurses to assume these codependent behaviors is also seen to evolve from externalized factors such as staffing shortages, work overload, fiscal constraints, patriarchal hospital systems and a



professional commitment to provide quality, caring and accessible health care for all (Yates & McDaniel, 1994). The social milieu of the work environment conditions nurses to use a method of coping which focuses so much upon the external environment that internal processes (e.g., emotions, desires) are forgotten or lost. Thus, codependent nurses sacrifice their own values to be close to others, they trust the opinions of others more than their own, and they believe that the quality of their lives depends upon the lives of other people (Whitfield, 1989).

The literature does not support the popular assumption that environmental stress is an urban phenomenon; however, many studies cite unique stressors that affect rural populations. Harsh environmental conditions, economic instability, lack of educational and career opportunities, an aging population, and health care access concerns present challenges for rural residents, particularly women (Bigbee, 1987; Case, 1991; Deitz, 1991).

There is a continuing trend that rural nurses tend to be older, more resistant to change and to have more unique relationships with clients and families (St. Clair, Pickard & Harlow, 1991). There is a persistent nursing shortage in rural areas which adds the stressors experienced by nurses of chronic recruitment, retention, fatigue and short-staffing problems (Turner & Gunn, 1991). Nurses must be generalists, maintaining currency and competency in an environment characterized by sparse resources. Often every nurse within a hospital setting may need to accept an additional assignment in

areas such as nursing education and staff development, infection control, quality assurance, respiratory therapy or dietary (Sterling, 1983, cited in St. Clair, Pickard & Harlow, 1991). This, together with a higher (than urban) visibility both on and off the job, can be difficult in terms of the intense community involvement with its "own" hospital, where nurses play roles as nurse, friend, neighbor, citizen, and family member.

#### Purpose of the Study

This study will examine the role of environmental work stressors and family-of-origin dysfunction in the genesis of professional codependency and compare rural and urban samples of nurses using those parameters.

#### Review and Critique of the Literature

Nurses have been and continue to be the subject of studies that explore their low self-esteem. In many nursing settings, programs have been developed that attempt to address esteem issues for nurses--stress reduction, assertiveness training, quality circles, etc., most frequently to no avail. Codependency is one way to conceptualize emotional and behavioral patterns which result from either dysfunction in the family-of-origin or dysfunction in other social institutions to which the individual nurse is exposed over time. In addition to the often rigid, patriarchal, bureaucratic systems operating in health care, the distinctive characteristics of rural nursing practice may foster critical elements of personality problems that are inherent in codependency.



### Codependency

Codependency has received extensive attention in the popular literature, but little has been published that offers empirical data on the construct. Authors offer a variety of theoretical frameworks with similar symptomatology, though some are more inclusive than others. All agree that symptoms include: instability and extremeness in thoughts, feelings and actions; lack of identity development with creation of a false self; a need to control self and others with low self-esteem and self-worth when these efforts fail; and caretaking to the exclusion of care of oneself. Also found are use of relationships to gain meaning, stress-related physical illness with or without depression, denial or repression of unacceptable feelings, especially anger, and difficulties with boundary setting. Codependency is further described as involving compulsive behaviors, communication problems, and difficulties with intimacy. It has been viewed as a personality style, a personality disorder, or a progressive disease that results in very dysfunctional patterns of living (Beattie, 1987; Cermak, 1986; Friel & Friel, 1988; Mellody, et al., 1989; Schaef, 1986; Subby, 1987; Woititz, 1983; Whitfield, 1991).

The illness model (Schaef, 1986) treats codependency as a primary disease with its own symptomatology, course, and treatment. This model describes codependency as the most common addiction and the basis for all other addictions and compulsions. As discussed by Haaken (1990), codependency was first described as a "disease" of "compulsive caretaking" (p.



397) found in spouses of alcoholics, and the meaning has now broadened to include children of alcoholics and nearly anyone involved with an individual with significant problems (e.g., psychopathology, illness). Some have stated that codependency qualifies as a personality disorder under Axis II of the Diagnostic and Statistical Manual of Mental Disorders, Third Edition--Revised (American Psychiatric Association, 1987), noting that dependent personality disorder describes many prominent features of codependency (Cermak, 1986; Kitchens, 1991).

Beattie (1987) and others (Mendenhall, 1987; DesRoches, 1990) view codependency more as a natural, somewhat universal personality trait which exists on a continuum and can become maladaptive. Beattie defines codependence as "a person who has let someone else's behavior affect him or her and is obsessed with controlling other people's behavior" (p. 31). The characteristics of codependency in this conceptualization include excessive caretaking, low self-worth, repression of thoughts and feelings, obsession, controlling, denial, dependency, poor communication, poor boundaries and other problems. Although the syndrome initially starts as a coping mechanism, it is progressive and leads to severe self-destructive behaviors. This experientially based definition generally requires the presence of a dysfunctional family.

Many authors in the psychology field conceptualize codependence as a personality disorder. Subby (1987), for example, defines codependence as "the denial or repression of the real self based on an erroneous assumption that love,

acceptance, security, success, closeness, and salvation are all dependent upon one's ability to do 'the right thing'" (p. 26). The parameters of codependence include difficulty identifying and expressing feelings, perfectionism, rigidity in thoughts and behaviors, overly responsible for others, extreme need for approval, powerlessness, conflict avoidance and others. The condition develops from turning the responsibility for life and happiness over to the ego (false self, child within, shame base) and to others.

Despite the widespread use of the term both in the popular press and in mental health and addiction treatment, no clear definition of the term has emerged which has led to criticism and loss of credibility. Regardless of which theoretical view one takes there is little empirical research investigating codependency's construct validity (Gotham & Sher, 1996). Critics of the concept note that it does not have diagnostic discriminative validity (Haaken, 1990; Anderson, 1994) and that there is no clear-cut clinical condition that corresponds uniquely to the concept (Gieryski & Williams, 1986). For example, Schaef (1986) concluded that everyone who is around a person involved in an addictive process is by definition a codependent. Beattie's (1987) list of conditions reflecting codependence ranges from problems of living to psychotic disorders. Whitfield (1991) states that codependency "may be mild to severe and most people have it. It can mimic, be associated with and aggravate many physical, psychological and spiritual conditions" (p. 8). Anderson (1994) argues that even if it were demonstrated that the behaviors, thoughts, and feelings associated



with codependency are present in most families of addicted people, it has not been shown that those symptoms are specific to these families. In fact, Kitchens (1991) states that "families that are headed by parents who are rigidly religious, psychotic, workaholics, have various sexual disorders, or are overtly rageful persons are among the kinds of families that are capable of creating codependence in family members" (p. 5).

Thus, many conclude that the codependence construct is overly inclusive and indiscriminate and is really only a catch-all description of highly diverse symptoms. This labeling of a wide variety of behaviors as addictions is known as the "diseasing of America" (Meacham, 1991, cited in Anderson, 1994). Proponents of the disease model, however, believe that codependency exhibits many of the characteristics of chemical dependency most notably tolerance, loss of control and self-delusion (Schaef, 1986). Some have subscribed physiologic origins. For example Cruse (1989) wrote, "Codependents may have a biological predisposition to self-defeating behaviors that alleviate pain. Like drugs, such behaviors as perfectionism or controlling upset the brain's neurochemical balances leaving the codependent craving more to feel normal" (Cruse, cited in Treadway, 1990). As described by Brown (1990), "the 'process addicted' person experiences a craving, is willing to incur losses to obtain the object, gets high on the process, and suffers withdrawal symptoms on separation from the object" (p. 1). In process addictions, no chemical substance is involved but the addictive

phenomenon is presumed an interpersonal process that mimics drugs in its effects on people. Just as chemical addictive behavior has been labeled "disease", the effort to refer to codependent behavior in the context of disease speaks to a general social tendency to call behavior that is a problem or confusing a legitimate focus of medical treatment and control. Part of the basis for this labeling may be economic. If one is dealing with a disease, there is justification for starting high-cost programs to treat it (Anderson, 1994; Krestan & Bepko, 1989; Uhle, 1994). Taken one step further, creation of a disease provides many new clients for those in the treatment industry.

Others have pointed out that associating pathology to the entire family is more broadly political. Krestan and Bepko (1989) note:

Since many families in treatment are affected by the behavior of the male alcoholic, describing a female spouse and children as also "sick" helps detour responsibility away from the male alcoholic. Since defining the alcoholic husband as "sick" implies that the wife is somehow stronger, better or more healthy threatens the balance of power in traditional families, the notion of codependency becomes a useful way of applying family systems principles in the interest of maintaining the cultural status-quo. (p. 219)

Haaken (1990) describes codependency as the "emotional condition of the oppressed" (p. 397). The codependency label, on a political level, becomes another tool in the oppression of women, fostering denial of male accountability.



Treadway (1990) concludes that "regarding problems in living as a disease leads to an abdication of personal responsibility" (p. 40).

The most compelling argument opposing the codependency label appears in a feminist and social framework. Feminists criticize codependency as pathologizing characteristics associated with women; blaming the victim, enhancing the adherence to a label, and legitimizing powerlessness and failure. Many of the symptoms experienced by so-called codependents are experienced by most women in American society at least some of the time. Twelve step programs emphasize powerlessness and the necessity to surrender the will to a higher power. Women are seen as accomplices to male addictions by enabling the other's behavior. Women are convinced that because of their caretaking and nurturing qualities, femininity itself is a pathology. Real and material conditions such as economic realities, lack of employment, child care concerns and fear get lost in a system that blames the victim. (Anderson, 1994; Haaken, 1990; Harper & Capdevila, 1990; Krestan & Bepko, 1989; Paape, 1993; Sauerwein, 1996).

Many feminist authors point out that the codependency movement never addresses the social roots of the problems associated with the condition. Women are socialized to base their self-esteem in their ability to make relationships work (Paape, 1993). The characteristics of codependency are viewed as the prescribed cultural roles of women (Anderson, 1994). The social structure of patriarchy induces the unequal distribution of power and resources

and the lack of options for women (Malloy & Berkery, 1993). Moreover, most proponents of the codependency model espouse the notion of the dysfunctional family as the source of codependent behavior. Then one must ask whose standard defines dysfunction. Krestan and Bepko (1989) state that "most people tend to share some common assumptions about health and normalcy. They are assumptions that reflect predominantly white, middle- or upper-class values" (p. 221). They continue, "Codependency presumes that there is such a thing as a functional family not influenced by gender inequality and that if we could re-achieve this seemingly functional structure, codependency could become a diagnosis of the past" (p. 222).

Although codependency has been criticized on points of definition, gender bias, medicalization, a lack of empirical research and social labeling, the strengths of the model cannot be overlooked. First, it is much easier to understand and relate to than family systems theory. Instead of describing interactive processes between components of a system, it portrays the thoughts and feelings of people in terms they can relate to emotionally. The concept of codependency is more clear than the abstract notions of enmeshment, fusion, and circularity (Clark, 1992).

Second, the movement originally began with the very powerful and important observation that children who grew up with alcoholic parents were affected in predictable and traumatic ways. Despite the dearth of empirical research, the qualitative and ethnological observations of countless family and



addiction therapists, physicians and psychotherapists support the hypothesis that a pattern of painful dependence on compulsive behaviors and on approval from others occurs more often in some families than in others. In addition, the codependency movement has benefitted many suffering persons. The self-help programs and literature have helped people feel better about themselves, leave abusive relationships, and change destructive patterns of behavior. Social networks have been created where before there was isolation. Self-care is being taught and practiced. Many treatment recommendations take a holistic approach, addressing spiritual, emotional, and physical recovery. Areas of potential health not previously present may become part of the recovering person's life.

While critics have pointed out that the codependency construct is inexact and undiagnostic (Haaken, 1990; Anderson, 1994), the popular literature that ascribes to it clearly suggest that codependency explains important themes in the lives of many--particularly women. A name is given to a broadly defined set of emotional problems, interpersonal pressures and dependencies that do result in psychological agonizing, physical maladies, and family and social ills (Schnieder, 1991). Thus it provides a message of hope for those involved, that is, a path to recovery. It empowers people to take their lives into their own hands.

Finally, the codependency movement provides a sense of community and belonging. Treadway (1990) comments, "Underlying the compulsive, grasping



materialism in our culture is a profound breakdown of our community, shared spiritual values, and sense of common purpose" (p. 42). In his essay on community well being, Wilkinson (1991) explains social well being in terms of human needs theory; "The transition from a social life oriented mainly toward lower-order needs to a social life oriented mainly toward higher-order needs obviously contributes to aggregate individual well-being" (p. 73). Because of codependency's connection with the 12-step model, it speaks to people's need for a sense of community, empowerment, and spiritual renewal (Mendenhall, 1989). In essence, people coming together, helping one another as part of helping themselves.

#### Professional Codependency

The linkage of the concept of codependency to professional helpers, in particular nurses, has been widely recognized and reported. It has been estimated that up to 28 million Americans have grown up in a family setting conducive to developing characteristics of codependency in children (Kolenda, 1989). Depending on the author, it is estimated that at least 80% of all nurses come from dysfunctional families or exhibit codependent behaviors (Black, 1981; Chappelle & Sorrentino, 1993; Woititz, 1983). In a study conducted by Holder et al. (1994), 69% of the nursing students surveyed were reared in a family where there was either alcoholism, sexual abuse, physical or family violence, with more than 58% reporting multiple factors related to dysfunction. Of those surveyed, 74% reported codependency traits. Yates and McDaniel (1994)

used two different assessment tools to assess codependency among practicing nurses. The Codependency Assessment Inventory (Friel & Friel, 1989) indicated that about one-third of the nurses had moderate to severe levels of codependency. On the Codependency Nursing Self-Assessment Inventory, (Snow & Willard, 1989) 12% to 25% of nurses reported personality extremes suggesting codependency. Wittman (1990) conducted a survey of occupational and physical therapy students and compared them to a sample of marketing and undecided majors to determine how many were adult children of alcoholics (ACOA). Results of this study indicated that there was a significant difference in the prevalence of ACOAs (33%) in the health care majors in comparison with the other group. The findings are similar to a previous study conducted by Condo (1987) in which 217 student nurses were found to have a 35% prevalence of parental alcoholism.

In their epic book on the subject of professional codependence, Snow and Willard (1989), through both their experience as therapists and nurses and through research they have conducted, studied five core issues identified as most relevant to codependence. They have found that approximately 60% of nurses believe their self esteem to be low, and 84% have boundary issues. Boundaries are defined as the ability to "know when we are being abused in some part of our reality, and knowing when we are offending others" (p. 41). On the issue of needs and wants, 55% of nurses view themselves as needless and antidependent, 16% percent view themselves as too needy or too dependent,



and 21% have issues in both extremes. Thus either nurses feel they do not have needs or, they get their needs met indirectly by taking care of the wants and needs of others. Snow and Willard believe that the fourth issue--balance--to be the behavioral symptom of codependence. Balance is a matter of maturity and moderation, not operating "in the extremes". Fifty nine percent of nurses practice confronting one crisis after another and consider it normal. Snow and Willard conclude that "issues of moderation efficiency prevent a nurse from developing and maintaining a dynamic theory of practice and from living and practicing in a balanced way" (p. 46). Finally, nurses are overwhelmingly perfectionists. The profession encourages each individual to act, work, and function in an accurate, timely and consistent manner or endure the shame for not being in control. In the end, Snow and Willard resolve that either nurses leave the profession because they can not handle the pain of feeling chaotic or they remain in the profession, cared for by the professional enabling of other codependents who want to mend their pain.

Professional codependency is generally thought to be precipitated by two different phenomenon or a combination of the two. It has been suggested that many people are drawn to the helping professions because it perpetuates the roles they played in dysfunctional families (Armstrong & Norris, 1992; Berry, 1988; Snow & Willard, 1989). As noted earlier, it does seem that nurses tend to have a higher incidence of family history of chemical abuse and possibly family dysfunction than does the general population. If codependency is itself a

form of addiction, it would follow that codependents would seek opportunities for the mood-altering effects of their behavior. They become dependent on the process for their feelings of identity and self-worth (Brown, 1990; Schaef, 1986). Ryan (1991) notes that the long-term effect of family dysfunctional behavior follow the individual into the work setting. Ryan adds that while all nurses do not come from families with an alcoholic parent (a form of dysfunctional family), many nurses grew up as caretakers in their homes. The competency that individuals develop from these life experiences is noteworthy, but there are liabilities that may be overlooked. Nurses who give without allowing others to give to them are "at a high risk for spiritual, emotional and physical burnout" (p. 13). Ryan further postulates that these same nurses are at risk for becoming addicted to alcohol, drugs, work, food, television, or any other substance or thing that can numb the nurse's pain or alter her or his mood.

Past family history teaches codependent nurses to strive to be perfect, to keep feelings personal and private and that to discuss problems would admit failure. The hospital setting reflects past life at home-- "family" is now the work group--and they may "parent" their peers and patients. Walter (1995) concludes, "career choice is no choice at all, merely another manifestation of pathological caring--a convenient trade-off of a dysfunctional family for a dysfunctional employer" (p. 80).

Whitfield (1991) and Schaef (1987) have hypothesized that codependency not only applies to individuals but to families, businesses, other



institutions, and even whole societies. Hospitals can be as dysfunctional as families (Arnold, 1990; Berry, 1988; Holder et al., 1994; Sherman et al., 1989; Yates & McDaniel, 1994). Arnold (1990) states:

[Hospitals] develop systems, either consciously or unconsciously, to meet their own needs. Within hospitals, the rules are frequently rigid and inflexible; individuals must take great amounts of time and effort to change them. Hospital personnel usually are assigned roles, and after they are placed in their roles, it is difficult for them to be seen differently. (p. 1581)

As in dysfunctional families, everyone is expected to become externally focused, and the dependent expects to receive more attention than anyone else. In hospitals, factors such as staffing shortages, work overload, fiscal constraints, fragmentation of care across shifts, the educational differences among practitioners, and a professional commitment to provide health care access for all causes nurses to take on unrealistic or inappropriate burdens (Arnold, 1990; Covello, 1991; Sherman et al., 1989).

From a feminist perspective, the hospital is an extension of a patriarchal society. Male physicians and administrators define the structure of obedience expected of nurses (Klebanoff, 1994). Physicians might yell at nurses and blame them for patient problems. Nurses then have various departments to blame. There are unwritten rules about being angry or expressing anger which apply to nurses in one way and to physicians in another. Because physicians

and administrators (who are predominantly male) generate the patient volumes needed to maintain the financial integrity of the health-system, the individual needs of nurses--creativity, satisfaction, and balance between work and leisure activities are devalued.

In hospitals, nurses frequently receive more rewards for focusing on the dependent--physicians, bureaucracy and patients--rather than themselves. Nurses who are willing to work extra hours, cover for others , or work well with an abusive physician are considered "good". Nurses are expected to "take care of everything" and be in control even though they are surrounded by complicated systems and interactions. They can give proper and extensive care to a patient, perform heroically, and the patient can still die. In the hospital system, nurses face the additional burden of expected perfection--the patient's safety and health. If a nurse makes a mistake, the patient's life could be in jeopardy or there may be legal implications. Sherman et al. (1989) see codependency behaviors of nurses as promoting the need to compromise between professional and personal needs. They note that there can be problems if the compromise always focuses on the needs of the hospital to the detriment of the individual. Similar views have been addressed by Malloy and Berkery (1993) who agree that caretaking needs to be reframed to prevent the nurse from taking on martyr-like behavior, and from taking caretaking failures as personal defeats.

Some nurses have taken issue with blaming the problems of the nursing profession on individual nurses. They believe nurses are shouldering more and



more of the blame for their sources of stress, while societal and health care systems are spared responsibility. Walter (1995) states, "Highly individualized solutions defuse the possibility of a strong collective voice, and do nothing to defy the ongoing tacit permission for abuse" (p. 80). Codependency, as viewed by Walter (1995), Sherman et al. (1989), Mullaney (1993) and others, is too broadly applied to the nursing profession and is mistakenly being enmeshed with the concept of caring as the essence of nursing. Malaney (1994) sees no value in attempting to explain nursing as a piece of the codependency syndrome. "Codependency has nothing to do with caring. The image of codependency is one of instability, and the process of codependency is about being unrelational" (p. 6). Walter adds, "Caring is simply a way of using nursing knowledge, yet nurses who use it too well or too often are considered sick" (p. 80).

Nurses may have a predisposition to feelings, thoughts and behaviors associated with codependency that they have brought from their family of origin or these tendencies may simply be a conditioned response to the every day stress of a not-so-healthy workplace. In either event, it can be argued, that nurses are generally not, as a group, a picture of health--self-defined, empowered, respectful of their physical, sexual, emotional and spiritual limits, proactive and able to recognize offenses to their personhood and be accountable for themselves (Snow & Willard, 1989). On the other hand, nurses have, through the years, contributed visionary ideas to the development of healing practices and served as models for change. Nurses have "the art of



caring to alleviate illness and to promote health as their unique commitment to society and the health care industry" (Sherman, et al., 1989, p. 28).

### The Rural Factor

Although many of those who have written extensively about codependency, mostly from an experiential basis, view it as a condition of the "self", they all recognize that the concept primarily manifests itself on a relational level (Whitfield, 1991). Wilkinson (1991) contends that "the individual as a person and the structure of the individual's subjective experience of self are themselves aspects or phases of processes of social interaction" (p. 69). This means that the well-being of the individual is required for social well-being and is therefore a criterion with which to assess the prospects for social well-being in a given community setting, either rural or urban. But does the context of ruralness in any way affect the individual in such a way that it becomes a factor in either the genesis or propagation of personality traits, especially those associated with codependency?

The answer may be in how one defines codependency. If it is primarily a disease or psychological condition brought on by dysfunctional family life, then one might argue that there should be a direct relationship between levels of family dysfunction and levels of individual codependency. If, on the other hand, institutions, localities, and even society itself can operate as the dependent, then one could theoretically make a relational statement based on characteristics of well-being (or ill-being) within the dependent.

Given that population density is one of the many characteristics of societal influence, one must study the factors that make the extremes different. First, "the extremes" of population density--namely, rural verses urban--are not easily distinguished. Conger (1996) concluded, after studying the census data and Bureau of the Census statistical methodology, that a meaningful approach to understanding the effect of population density is that of a continuum. Pahl (1966, cited in Bushy, 1991) criticized the use of the rural-urban continuum, suggesting "that many *continua* and discontinuities exist both within and between rural and urban areas" (p. 548). After reviewing the literature, Lee concludes that while controversy still exists as to whether rural is really different than urban, two characteristics persist when considering the definition of rurality. The first is low population density. This characteristic affects: (a) communication and transportation patterns; (b) the networks and interactions between family, friends, and neighbors; and (c) the availability (or lack of) special services (Cordes, 1985, cited in Lee, 1991). The second major characteristic of rural is its diversity. The great diversity of the rural environment is much more evident as specific definitions of the components and degree of ruralness have occurred.

A summary of Conger's (1996) findings after reviewing statistical data on substance abuse include many similarities among rural and urban areas. Many people living in rural areas face a degree of economic disadvantage more similar to residents of impoverished central cities than to those living in the suburbs. Conger concurs that rural places experience all of the ethnic, cultural, historic,



and economic diversity of urban America. The stresses and strains of rural life create the same risks for alcohol, tobacco, and other drug use as found in metropolitan centers. The review of data from large nationally representative samples regarding substance use prevalence showed that there is little difference between larger and smaller places in term of the proportion of the population using substances of some kind. However, nonrepresentative community studies suggest that there is great variability among rural communities in terms of rates of substance abuse.

When gender is applied to the context of rural-urban differences, the literature reveals a somewhat wider divergence of attributes, although the magnitude of the discriminative power of those factors is decreasing (Bescher-Donnelly & Smith, 1981; Bigbee, 1987; Mansfield, Preston & Crawford, 1988). A general societal perception is that women living in rural areas achieve lower levels of education and have less diversity in their occupations than women residing in urban communities. This phenomenon is due in part to isolation and lack of opportunity. Available jobs are likely to be low-paying and low-status jobs primarily in clerical, technical, and service areas. Distance is a barrier to formal and technical educational opportunities.

Degree of change as a societal factor is accelerated for rural women most notably by their increased labor force participation (Walters & McKenry, 1985). Between 1980 and 1990 alone, the number of nonmetropolitan women over age 16 in the workforce increased by 4.5 million or 53% (Bescher-Donnelly

& Smith, 1992). As Walters and McKenry (1985) point out, "employment outside the home has radically transformed rural women's roles and introduced strain into the traditional family structure" (p. 291). Rural women may be particularly "at risk" for emotional stress because their changing roles present a greater challenge to the traditions of rural life. Until recently, the role of rural women has reflected the traditional value system of the rural culture: conservative, traditionalist, change-resistant, family-oriented. The scarcity of child care in rural areas adds to the burden of working mothers (Bigbee, 1987; Mansfield et al, 1988).

Research has identified other unique stressors present in rural areas but has not necessarily supported a variation in magnitude of those stressors. Bigbee (1987) found no significant difference in stressful life events, either positive or negative between rural and urban women. Rural women tended to report environmentally related stressors more frequently than urban women, while urban women reported more financially related stressors. Similarly, Mansfield et al. (1988) reported comparable levels of stress between rural and urban females. For both groups, stress related to family and friendship matters was most significant, followed by job-related stress. Lifestyle factors (socioeconomic level, young children at home) were important predictors of stress for rural but not urban women, while poor health predicted stress for both groups. Coward and Jackson (1983, cited in Bigbee, 1987) cited several economic and employment stresses that particularly effect rural families,



including poverty, unemployment, and the shift in employment away from agriculture. In addition, environmental stressors particularly effecting rural families include isolation, due to distance and topography, and weather.

Once-prominent factors such as marital status, health-seeking behavior, fertility rates, and family support that differentiated rural from urban women now show less significance (Bigbee, 1987; Mansfield et al., 1988). The divorce rate remains lower for rural women than urban females. Rural females, when compared with urban groups, tend to marry and give birth to a first child at younger ages; have more children; complete childbearing earlier; interact frequently with kin, particularly the spouse; and maintain a traditional sex role orientation (feminine, homemaker role) (Haney, 1982; Lamke, 1989; Lee & Cassidy, 1981, cited in Pass, 1991, p. 147-149). How these factors effect the rural milieu is unknown but one element that is an important influence on social life is the increasing numbers of elderly in rural areas. While average age is increasing throughout the United States, the rate of increase is accelerated in rural areas due to the migration of younger people to Urbana. Population age as a factor in the social environment predicts distinctions in health status, social support and role orientation (Bushy, 1991).

#### Codependency and Rural Nurses

The literature suggests that codependency is prevalent in nurses as a group and that there are unique stressors and characteristics that make up the rural milieu. Divergent role socialization in nursing may contribute to or

exacerbate the respective levels of codependent attributes among nurses. Long and Weinert (1989) found that health care providers in rural areas must deal with a lack of anonymity and much greater role diffusion than providers in urban or suburban settings. They explain:

There is an inability to keep separate the activities and behaviors of the individual nurse's various roles. In a small town, for example, the nurse's behavior as a wife, a mother, and a church attender are all significantly related to her effectiveness as a health care professional in that community. Further, in their professional role, nurses reported experiencing role diffusion. Nurses are expected to perform a variety of diverse and unrelated tasks. On a single shift, a nurse may work in obstetrics delivering a baby, care for a dying patient on the medical-unit, and initiate care of a trauma patient in the emergency room.

Likewise, on evening shift or weekends, a nurse may be required to carry out tasks reserved for the pharmacist or dietician on the day shift. (p. 389)

Sigsby (1991) adds that the more depth of relationship that exists between the patient and nurse, the greater the stress for the health care provider. She notes "Clinical terms and principles seem hollow and sterile when the patient is also a long-time friend. Loss belongs to the nurse as well as to the patient and family" (p. 524). Although all nurses may find themselves caring for a friend on occasion, the majority of patients will be well known to the rural nurse. This generalist work role and the lack of anonymity of rural nurses are substantiated



by findings and descriptions from several rural areas of the United States (Biegel, 1983, cited in Long & Weinert, 1989; St. Clair, Pickard, & Harlow, 1986).

The potential development of a reciprocal codependent relationship between nurse and client is a likely outcome of many community oriented nursing interventions because of the long-term association frequently maintained. In addition, Sherman et al. (1989) assert that "the intensity and complexity of many client care needs often mandate nurse-client involvement with many local, state, and federal agencies where the nurse is the pivotal link between client and agency" (p. 28). In rural areas, the bureaucratic systems that define both eligibility and scope of community based services are removed from the actual situation. This regulation of service need and provision of service by a remote resource creates an environment in which codependent behaviors can develop for both the nurse and client.

Rural dwellers are less likely to accept help and services from those seen as outsiders. Data from Wienert (1983) indicated that rural dwellers relied primarily on family, relatives, and close friends for help and support. Studies in rural Maryland (Salisbury State College, 1986, cited in Long and Wienert 1989), the Appalachian area (Counts & Boyle, 1987) and Nova Scotia (Ross, 1982) support this supposition. Winstead-Fry (1989) characterizes rural persons as "not easily accepting of help from others, especially from professionals of a higher status". She continues, "These characteristics create an interesting dilemma for nurses. Often the first person called upon in an illness is the local

nurse. Because there is a rural tradition of woman as healer, however, the nurse is not perceived as a valuable professional, but as a woman with special knowledge" (p. 133).

Thus, traditional gender socialization of rural women, and of nurses, defines identity in the context of relationship and judges identity by a standard of responsibility and care. Certainly one could argue that the primary tenants of codependency--disvalue for intrinsic worth and weak personal boundaries--could be exacerbated in the individual nurse when she is operating in a social environment where the nurse is "all things to all people" at work, at home and in the community.

When boundaries are weak, emotional individualism does not take place and identity is validated through relationships with others and responsibilities for others (Uhle, 1994). Over responsible behavior is exaggerated when one person does too much emotionally or functionally for another. If the nurse cannot distinguish between her problems and someone else's (as in rural life where "your business is every one else's business") their natural inclination is to believe that it is their own shortcomings that cause the inability to "handle it all".

### Conclusion

Codependency has been theorized about, characterized, diagnosed, treated, written about and criticized. There remains an element of usefulness about the construct in that it is a means to understand underlying patterns in relationships. Although some who have contemplated the subject of professional



codependency infer that the condition prediposes career choice, others view it as a manifestation of a dysfunctional healthcare system and its primary institution--the hospital. Since family dysfunction is fairly uniformly distributed throughout the population, it is plausible the differing levels of codependency attributes among subgroups could be correlated with societal variables.

While the concept of ruralness has unique characteristics, so does that of urban, depending on how each is defined. Besides the factor of population density and a more rapidly aging population, rural areas are subject to the same diversity and problems as that of urban communities. For nurses and nursing, however, there appears to be some distinct differences in practice in rural areas: generalist practice, role diffusion, lack of anonymity and its associated stressors and lack of peer support. Since these conditions define the workplace for rural nurses, it can be argued that these nurses are susceptible to low self value and impaired personal boundaries--defining characteristics of codependency.

### Significance

Recent research points to a significant reason why nurses burn out: they work in a "toxic environment" (Cullen, 1995). A toxic environment refers to "the pressure that's put on a nurse by the external organizational forces that determine the conditions under which they work" (Briles, 1994, p. 23). The health care system contributes to nurse burnout through its multiple regulations, reimbursement issues, and mandates. The institutional system creates structural and environmental obstacles for nurses--short staffing, mandatory

overtime, and being put in the position of having to lower their standards to accommodate fiscal agendas. Society expects nurses to be achievers and to fill traditional feminine roles as caretakers and nurturers. Nursing education and socialization foster idealism, perfectionism, self-sacrifice and sensitivity to the needs of patients, physicians and institutions. (Arnold, 1990; Treadway, 1990; Johnson, 1992; Yates & McDaniel, 1994; Cullen, 1995).

Studies have demonstrated that nursing care is the primary factor in how patients view their hospital stay (Huff, 1997). When nurses have unresolved issues with control, collaboration, influence, autonomy and respect, they pass these dissatisfactions on to co-workers and patients. Nurses are the closest point of service. Unhappy nurses at the bedside can translate into lower quality of care, unhappy patients and high nurse turnover.

In the literature many nurses are reported to suffer from compassion fatigue, internalized oppression or professional codependency. These terms have in common a nurse who is a perfectionist, takes more care of others and not enough of herself, is an idealist, lacks sensitivity to her own emotions and is very vulnerable to burnout. A 1998 search of the Cumulative Index of Nursing and Allied Health Literature (CINAHL) produced 569 articles related to nursing burnout. The reality of the prevalence of burnout in nursing is disenchanted nurses who are likely to change jobs, take part-time employment or look for another profession.



The U.S. Bureau of Labor Statistics projects that the employment of registered nurses will grow faster than the average occupation through 2006 (U.S. Bureau of Labor Statistics, 1997). However, the number of entry-level nursing students has dropped for the last three years (American Association of Colleges of Nursing, 1997). Students perceive that because hospitals are downsizing, there is a decreased demand for nurses (Hellinghausen, 1998). Other facts (in addition to fewer nursing school applicants) fueling a continued nursing shortage include intentional enrollment cutbacks at schools of nursing due to faculty shortages and fiscal constraints; rapid expansion of new roles in nursing, from case managers to nurse practitioners; rising acuity in hospitals and home care; an ever-increasing average age of nurses which means many retirements in the near future; replacement of nurses with unlicensed assistive personnel; and an aging of the baby boomer population resulting in an increasing demand for health care through 2030. (Brewer, 1998; Hellinghausen, 1998; Huff, 1997; Turner & Gunn, 1991).

Considering the increased demand for nurses, the decrease in supply of nurses and the prevalence of burnout issues within the nursing profession, it is paramount that workplace and nursing issues that contribute to job satisfaction, retention and quality care are recognized. Codependent nurses can suffer both emotionally and spiritually: their self esteem is low; they can't accept their innate worth as persons; they endure stress related health problems; they have difficulty setting boundaries and resolving conflicts; and workplace resentments



interfere with personal relationships. Health care institutions, too, pay a price, in poor job performance, absenteeism, and turnover among nurses. It costs a lot to replace an experienced nurse lost to burnout due to unrecognized, untreated professional codependency.

### Research Questions

Three research questions were addressed in this study:

- (1) Is there a difference in the codependency scores between rural and urban nurses?
- (2) Can differences in codependency scores be related to work environment?
- (3) Can differences in codependency scores be related to dysfunction in the family-of-origin?

### Theoretical Framework

Field theory, derived from quantum physics, states that fields underlie all matter and are considered "regions of influence with characteristic patterns" (Crowell, 1998, p. 28). There is no open space. Everything in a system that is not matter is field. A field is that which "underlies all matter and influences that matter" (Crowell, 1998, p.28). Fields have no boundaries. Anyone touched by a field is part of it. Fields can be felt as forces--some attract, some repel. They are perceived through all senses and emotions and manifest as "polarized roles" such as male/female, outsider/insider, leader/follower.

The major pretense of Field theory is that individuals, groups and organizations relate within systems. The holistic self-organizing properties of

systems at all levels depend upon morphic fields: fields influence the systems and vice versa. Fields are never static but constantly changing because of the ebb and flow of roles in the field. It is this disequilibrium within the field that moves the entire system toward greater complexity.

According to field theory no one is separate. Each person is a field and is in mutual process with others and with the environment at all times. All people are connected. When this is accepted, fear is diminished and conflict becomes less threatening. Chaos materializes when "the system, in an attempt to create an essential unity of purpose, tries to control, categorize, cajole and structure change" (Sheldrake & Rupert, 1995, pg. 10).

Not only does each individual influence field, but the field itself influences group behavior. Working through group issues within the group field is process work. The problem is a teacher. Process work allows events to flow, even if painful, not shutting off feelings but addressing them with compassion and awareness. A group is congruent when what it does is the same as what it says it believes. Conflict can interfere with achieving congruence; if there are unspoken beliefs or unrecognized opinions, confusion and tension occur.

Sheldrake and Rupert (1995), imagine organizations and organizational space in terms of fields, with employees as waves of energy, spreading out within the organization, ever growing in potential. A field in an organization is the milieu in which relationships take place. Mindell (1992) describes organizations as "characterized not only by their overt and identifiable structure,



purpose and goals, but also by their emotional features such as relationships, conflicts, jealousy and envy, as well as altruistic drives, spiritual needs and interest in the meaning of life" (p. 32). In this conceptualization of organizations, field is an integral concept used to explain "forces" at work in the subconscious environment.

Field theory is broad and encompasses several concepts: system, field, matter and force. As a guide for this study, systems are seen as families and as health care institutions; fields as relationships, emotions, patterns of living and understanding; matter as people and the physical environment; and force as the energy used to exert influence, disequilibrium or polarization within conscious or subconscious environment.

In addition to Field Theory, this study was also guided by the Self Psychology Theory which has been used repeatedly by researchers to describe their observation of spouses of alcoholics (Whitfield, 1991). Although rooted in Freudian ideology, this theory has begun to clarify true identity as "true self" rather than ego. Self Psychology Theory is based on the importance of early childhood development of the psyche, the importance of dynamics in relationships and the dynamics of projective identification (Cashdan, 1988).

Defined by Cashdan (1988), projective identification is a "pattern of interpersonal behavior in which a person induces others to behave or respond in a circumscribed fashion" (p. 62). In healthy interaction, giving and receiving tend to occur on a more conscious level of awareness on the part of both



people. In contrast, the use of projective identification requires the co-operation, usually unconscious, of two or more people, each having a "lost self" and focusing (that is, projecting, using and blaming) on the other, to their own detriment. Self Psychology Theory helps move the individual into systems where relationships can be addressed--thus is connected naturally to Field Theory. It also is a way to conceptualize codependency in the broader context of dynamic and responsive systems.

### Definitions

For the purpose of this study the following definitions were used:

Codependency: A pattern of behaviors by a nurse that meets other's needs at the expense of her/his own characterized by perfectionism, a need to control others and compulsive care giving (Yates & McDaniel, 1994).

Rural: Persons living in a place of 2,500 persons or less. (U.S. Congress, Office of Technology Assessment, 1990)

Urban: Persons working and living in a metropolitan statistical area (a city of 50,000 or more residents, or an urbanized area with at least 50,000 people that is itself part of a county or counties with at least 100,000 total residents (U.S. Congress, Office of Technology Assessment, 1990).

Nurses: Registered nurses holding a current license who practice at least 12 hours a week as patient care givers in a health care institution.

Dysfunction: a history of emotional or physical abuse or neglect, chronic

mental or physical illness, chemical dependency or presence of a strong religious system in the home (Woititz, 1987).

Family of Origin: the person or group of persons who lived in the subject's home on a daily basis until the subject's 18th birthday.

Acute care: a hospital or ambulatory care setting in the following clinical areas: critical care, maternal/child health, medical/surgical, oncology, pediatrics, or perioperative.

### Assumptions

1. That the respondents completed the Friel Co-Dependency Assessment Inventory (Friel, 1985), demographic, personal, and professional inventories honestly and accurately.
2. That codependency represents an identifiable and measurable pattern of human behavior and feeling.
3. That codependency is associated with dysfunction in the family-of-origin (Beattie, 1987; Friel & Friel, 1988; Kitchens, 1990; Subby, 1987; Whitfield, 1991).
4. That codependency is associated with employment in the helping professions (Snow & Willard, 1989).
5. That codependency is associated with dysfunction in health care institutions (Arnold, 1990; Davidhizar & Eshleman, 1992; Schaef, 1987; Snow & Willard, 1989).

6. Rural nursing practice is distinct from urban nursing practice in that rural practice is characterized by a generalist work role, lack of anonymity, long term nurse/client associations and personal identity based on professional relationships (Long & Wienert, 1989; Sigsby, 1991).

#### Limitations

1. The findings cannot be generalized to other regions of the United States. Variables such as culture, ethnicity and socioeconomic characteristics of the social milieu in different locales may effect the genesis and manifestation of codependency traits in persons, families, institutions and communities.

2. The codependency scores are limited to the reliability and validity of the Friel Co-Dependency Assessment Inventory (Friel, 1985).

3. The tool used to measure variables associated with codependency does not encompass the full range of behaviors and emotions that could characterize interactions in a dysfunctional family.

4. The measurement of the health of the working environment is limited to the reliability and validity of the Ward Organizational Features Scale (Adams, 1995).



## CHAPTER II

### METHODOLOGY

This descriptive study utilized a survey approach with a random sample. Data were gathered to identify variables associated with professional codependency, in particular population density of practice location, demographic characteristics, family characteristics and work environment.

#### Population

The population in this study is registered nurses who are currently practicing in an acute care setting and who live in a designated rural or highly urbanized locale in North Dakota and Minnesota.

#### Sample

The rural and urban samples were obtained by sending questionnaires through the U.S. Mail. For the rural sample, addresses were procured from the North Dakota State Board of Nursing mailing list of all registered nurses who work in acute care settings as of their latest licensure in North Dakota. Three hundred addresses were randomly chosen using only zip codes of locales in counties designated as rural or frontier by the U.S. Bureau of Census (U.S. Congress: Department of Commerce, 1990). The urban sample was selected from a mailing list obtained from the state of Minnesota with the identifiers of (1) registered nurses, (2) zip codes of residences inside or adjacent to downtown

Minneapolis and (3) area of clinical practice. Three hundred addresses were randomly chosen from this list. Surveys were returned in self-addressed, stamped envelopes.

Data were collected by use of three questionnaires. The first tool (see Appendix B) was adapted from a tool developed by Woititz (1987) to gather information concerning demographic data and variables associated with codependency. These variables include the birth order in the family of origin; abuse of alcohol or drugs by a parent, sibling, grandparent, or care giver; history of physical abuse of self, parent, or sibling; flexibility of the family unit and the presence of a strong religious system in the home. Clinical investigation of codependent family situations has shown a relationship between being a first child in a family and control issues that are problematic in the family. An item was generated for each variable. The option for each question was "Yes" or "No" except for the item regarding religious influence in the home which was "Strong", "Moderate" or "Weak".

The Woititz tool was scored by assigning a value of 1 to "Yes" answers and 0 to "No" answers. Religious influence was scored as a 1 for "Strong", and a "0" for "Moderate" and for "Weak". A mean response was calculated for the tool as a whole.

The second tool (Appendix C) was adapted from the Ward Organizational Features Scale (WOFS) (Adams, 1995). In the original scale, each set of six scales comprised 14 subscales which measured discrete dimensions of acute



care hospitals. This comprehensive set of measures related to: the physical environment of the ward, professional nursing practice, ward leadership, professional working relationships, nurses' influence and job satisfaction.

A study of a nationally representative sample of 825 nurses working in 119 acute wards in 17 hospitals provides evidence for the structure, reliability and validity of the scale. Test-retest reliability of the scales was computed by the authors using a Pearson correlation coefficient, where each subscale achieved a correlation coefficient of 0.7 or above. Items grouped together by factor analysis were tested as scales for internal consistency and reliability using Cronbach's alpha. Of the 14 subscales developed, only two failed to achieve a Cronbach's alpha score of  $> 0.7$ . These subscales were retained by the authors on the grounds that the factors from which they were derived achieved eigenvalues of  $> 1$ , and because they were considered conceptually important. Items from these subscales were not used in the current study.

The modified form of the WOFS was comprised of 30 items related to professional nursing practice, professional relationships and nursing leadership. Each item on the WOFS has 4 scaled responses ranging from strongly agree to strongly disagree. The responses for items worded in the negative were reversed (see Appendix C). A mean response was calculated for each item, the subscales and scale as a whole.

The final tool is the Friel Co-dependency Assessment Inventory (see Appendix B) (Friel, 1985). This tool provides a self-assessed score of



codependency and covers the following areas: self-care, self-criticism, secrets, "stuckness", boundary issues, family of origin, feelings identification, intimacy, physical health, autonomy, over-responsibility/burnout, and identity. The respondent is asked to answer "yes" or "no" to each of 60 statements in terms of how they generally feel. Answers to odd numbered questions are reversed. "Yes" answers are summed. Scoring is as follows: <20: few codependent concerns; 21-30: mild to moderate codependency; 31-45: moderate to severe codependency; > 45: severe codependency.

The initial reliability figures for the Friel tool using KR-20 (Richardson Standard Formula) were in the range of 0.83 to 0.85 (Friel & Friel, 1987). Friel and Friel used fairly homogenous samples--that of significant others who were in the family programs of a chemical dependency treatment center and professional counselors and therapists in the chemical dependency treatment field. Co-dependency scores in this group had a narrow range between 30-35.

#### Data Analysis

Descriptive statistics were used to characterize the answers to the questionnaires and the demographic data. Mean scores on the Ward Organizational Features Scale for the entire sample and for respective rural and urban samples were calculated. Although The Friel Codependency Assessment Inventory can be used as a ratio scale, in this study it was used as an ordinal scale. "Levels" or "categories" of codependency are easier to understand and operationalize and are more useful clinically (Friel 1985). Cronbach's alpha

coefficient was utilized to determine internal consistency reliability for the Friel Assessment and the WOFS.

A score was derived for the family dysfunction variable by summing the number of positive responses to the five questions regarding family characteristics linked to codependency. Mean scores were calculated for the entire sample and for respective urban and rural samples.

To examine the relationship between codependency and population density a Chi-square test was employed. The assumptions of the test were met in that both variables used nominal measurement scales and the sample in this study was random and independent. To examine the relationship between codependency, family dysfunction and organizational features, a one-way analysis of variance (ANOVA) was used with codependency scores as the dependent variable and responses to the family demographic and organizational features survey items as independent effects. When a main effect was significant ( $p < 0.05$ ), post hoc Bonferroni analyses were used to identify significant differences between variances. The level of significance was set at 0.05 for this study.

#### Protection of Human Subjects

Approval to conduct the study was attained from the University of North Dakota's Institutional Review Board. Participation in the study was entirely voluntary and potential study subjects were informed by a written introduction, attached to the questionnaire, that completion of the questionnaire indicated

consent to participate. No known risk to the subjects was associated with participation. Significant insight into their current life situations and reflection on their nursing careers were potential benefits to the participants. A scoring guide for the codependency inventory was supplied to assist participants to realize this benefit, should they desire.

Participants were assured that this study was about nurses and not an evaluation of themselves as individuals. Questionnaires were not marked for identification and all returned questionnaires were kept in strict confidence by the researcher. Only aggregate data from the study is published in this report. Excerpts from a letter included with one returned survey were used without identifying the writer and with her written consent.



## CHAPTER III

### RESULTS

The purpose of this correlational study was to investigate codependency in relationship to population density, dysfunction in the family of origin, workplace characteristics and demographic variables. Included in this chapter is a description of the study sample followed by an analysis of the results addressing each research question. The Statistical Package for the Social Sciences--Revised (SPSS-PC) was used for data analysis. Significance was set at  $p = .05$ . The research questions were:

- (1) Is there a difference in codependency scores between urban and rural nurses?
- (2) Can differences in codependency scores be related to work environment?
- (3) Can differences in codependency scores be related to dysfunction in the family-of-origin?

#### Sample Description

A total of 600 surveys were mailed, 300 to rural addresses and 300 to urban addresses. A total of 103 surveys (34%) were returned from the rural sample and 99 surveys (33%) were returned from the Minneapolis, Minnesota (urban) sample. The majority of subjects in both subsamples were female, in

their 30's and 40's and married. Occupationally, the average tenure in nursing was 15.7 years and the mean number of years in their current nursing position was 7.5. Demographic characteristics of the population from which the sample was drawn may vary from the actual sample. Selected demographic variables are represented in Tables 1 and 2.

Table 1

Sample Demographic Characteristics (Nominal)

Variable	n	Percent
Gender	6	3
Male		
Female	195	97
Population density		
Urban	99	49
Rural	103	51
Marital Status		
Married	137	69
Single	42	21
Divorced	18	9
Widowed	1	1

Sample Demographic Characteristics (Ratio)

Table 2

Variable	Mean	<u>SD</u>	Minimum	Maximum
Age (n = 201)	40.68	10.36	22	68
Years as a nurse (n = 201)	15.71	11.21	1	46
Years in current position (n = 193)	7.49	6.96	1	32

Dysfunction in the family of origin, in particular those specific, characteristic patterns that are repeatedly found in the clinical and scientific literature on the subject of codependency is represented by responses to historical questions: In your family are you the first child? When you were growing up did you have personal exposure to abuse of alcohol or drugs by a parent, sibling grandparent or care giver? When you were growing up were you exposed to physical or emotional abuse of self, parent or sibling? How flexible was your family when you were growing up? What was the religious influence in your home when you were growing up? Table 3 summarizes the historical data.

The Friel Codependency Assessment is a 60 item self analysis of behavior patterns that, when grouped together, provide a level of codependence (Friel & Friel, 1987). The Friel Codependency Assessment measures traits linked by clinical observation and empirical study to the construct of



Table 3

Family Historical Data

Variable	n	Percent
First Child		
Yes	64	31.7
No	136	67.3
Exposed to Substance Abuse		
Yes	65	32.2
No	135	66.8
Exposed to physical or emotional abuse		
Yes	73	36.1
No	126	62.4
Family was		
Flexible	113	55.9
Rigid	86	42.6
Religious Influence		
Strong	88	43.6
Moderate	87	43.1
Weak	26	12.9

codependency. The tool is scored by summing the number of "yes" answers to questions about self-care, self-criticism, secrets, "stuckness", boundary issues, identification, intimacy, physical health, autonomy, over-responsibility/burnout, and identity. The higher the number of "yes" answers, the greater the tendency for codependence. Based on the number of negative traits the subject identifies

in his or her life, the score is placed in categories of relative codependence with "1" having few codependency concerns and "4" exhibiting severe codependency. Scoring for the questionnaire is as follows: <20 few codependent concerns; 21-30 mild to moderate codependency; 31-45 moderate to severe codependency, and; >45 severe codependency.

The Cronbach's Alpha reliability analysis revealed an alpha score of 0.9100 ( $n = 188$ ) for the Friel Assessment. Fourteen of the cases were not used due to missing items. Table 4 presents the frequencies of codependency scores obtained in the sample.

The Ward Organizational Features Scale (WOFS) was developed to permit measurement and numerical description of salient acute-care nursing unit features. This 30 item tool was used in the present study to determine the level of functional characteristics in the socio-technical work environment including management practices, professional relationships and professional practice issues. It is scored on a 4-point Likert scale with "4" = strongly agree and "1" = strongly disagree. The higher response score indicates a lower concentration of stresses detrimental to feelings of personal well-being in the workplace.

The Cronbach's reliability analysis of the WOFS revealed an alpha level of 0.8869 ( $n = 197$ ). Seven subjects did not complete the scale. The mean score on the WOFS was 2.3 ( $SD = 0.54$ ). These data are represented in Table 5

Table 4

Codependency Levels

Codependency Level	n	Percent
Few codependency concerns	60	29.7
Mild to moderate codependency	66	32.7
Moderate to severe codependency	51	25.2
Severe codependency	11	5.4

Table 5

Mean Organizational Features Scores of all Subjects

Variable	n	Mean	SD	Minimum	Maximum
Organizational features score	197	2.34	0.54	1.00	3.67

## Research Questions

Research Question #1

Is there a difference in codependency scores between urban and rural nurses? While only 25 percent of urban nurses exhibited moderate to severe codependency (level 3 and 4), almost 40 percent of rural nurses fell into these categories (Table 6). However, when the full range of codependency scores



were analyzed, there was not a statistically significant difference in the codependency scores between the urban and rural nurses (Chi-square = 6.895,  $df = 3$ ,  $p = .075$ ).

Table 6

Population Density by Codependency Level

Codependency Category	Urban	Rural
1 Few Codependency Concerns	31	29
2 Mild to Moderate Codependency	37	29
3 Moderate to Severe Codependency	21	30
4 Severe Codependency	2	9

Research Question #2

Can differences in codependency scores be related to work environment?

The Ward Organizational Features Scale measures the characteristics of the nursing unit work environment that may impact the nurse on a personal level. The scale is scored from a "4" which is strongly agree to "1" which is strongly disagree to positive statements about unit management, relationships with physicians, ancillary staff and other nurse co-workers, and practice issues such as nursing autonomy, support and influence. A higher score indicates a higher

level of vitality and less stressors on the nursing unit. Table 7 shows mean WOFS scores for each level of codependency.

Table 7

Organizational Features by Codependency Level

Codependency Level	<u>Ward Organizational Features Scale</u>		
	<u>n</u>	<u>Mean</u>	<u>SD</u>
1	58	2.47	0.54
2	66	2.37	0.52
3	50	2.27	0.56
4	11	1.91	0.42

Table 8 represents an ANOVA analysis revealing a significant difference in the WOFS score and the four different categories of codependency scores. The findings indicate that an increased perception of stress in the workplace is related to an increase in Codependency level (Table 8)

Bonferroni post hoc tests demonstrated that the significant differences are accounted for by comparisons between the rural subjects with few to moderate levels of codependency (levels 1 and 2) and those with severe codependency (level 4).

Table 8

Summary Table for Analysis of Variance of Organizational Features by  
Codependency Level

	SS	df	MS	F	p
Between	3.276	3	1.092	3.848	0.011
Within	51.369	181	.284		

Research Question #3

Can differences in codependency scores be related to dysfunction in the family of origin? Dysfunction in the family of origin was measured using 5 questions about the subject's family history that have been linked by clinical observations and empirical research to the codependency concept. The number of positive responses for the items was summed. The higher the number of positive items, the greater the presumed dysfunction. A mean family dysfunction count was calculated for each level of codependence (Table 9).

The nurses with fewest codependency concerns had an average of 1.68 (SD = 1.10, n = 60) family risk factors for codependency while the 11 nurses in the category of "severe codependency" had a higher mean score on the dysfunctional family scale (M = 2.18, SD = 1.40). However, an analysis of variance showed the number of family predispositions when examined within each category of the codependency scores was not statistically significant



Table 9

Family Dysfunction by Codependency Level

Codependency Score	n	<u>Family Dysfunction Items</u>	
		Mean	<u>SD</u>
1	60	1.68	1.10
2	66	1.89	1.12
3	51	1.96	1.13
4	11	2.18	1.13

(Table 10). In addition, the family history items were collapsed to determine if there was a significant difference in codependency scores between two theoretical groups; those having less dysfunction (0-2 positive items) and those having more dysfunction (3-5 positive items). No significant difference was found. The findings indicate that an increase in family-of-origin dysfunction is not related to an increase in codependency level.

Table10

Summary Table for Analysis of Variance of Family Dysfunction by  
Codependency Level

	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>E</u>	<u>p</u>
Between	3.605	3	1.202	0.934	0.425
Within	240.404	184	1.287		

## Other Findings

To better understand how population density, family-of-origin dysfunction and organizational influence affected the codependency score, the relationships between the variables were examined separately. In both the urban group of 91 nurses and the rural group of 97 nurses, an analysis of variance showed no statistically significant difference in codependency scores when tested against family dysfunction (Table 11 and 12). Therefore family dysfunction is not related to codependency for the whole group of nurses or for either group independently.

Table 11

Summary Table for Analysis of Variance of Family Dysfunction by  
Codependency Level for Urban Nurses (n=91)

	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between	7.602	3	2.534	1.964	0.125
Within	112.244	87	1.290		

In contrast to the finding that there is no relationship between the codependency score and dysfunction in the family-of-origin, there appears to be a relationship between institutional influence and codependency when population density is analysed separately. For the urban nurses there is not a statistically significant relationship (Table 13) but for the rural nurses there is a significant difference

Table 12

Summary Table for Analysis of Variance of Family Dysfunction by  
Codependency Level for Rural Nurses (n =97)

	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between	3.340	3	1.113	0.884	0.453
Within	117.175	93	1.260		

(Table 14). Bonferroni post hoc tests demonstrated that the significant differences are accounted for by comparisons between the 28 rural nurses with few codependency concerns who had an average score on the Ward organizational tool of 2.38 (SD = 0.49) and the 9 rural nurses with severe codependency who scored 1.84 (SD = 0.41).

Table 13

Summary Table for analysis of Variance of Organizational features by  
Codependency Level for Urban Nurses (n = 91)

	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between	0.424	3	0.141	0.467	0.706
Within	25.689	85	302		



Table 14

Summary Table for Analysis of Variance of Organizational Features by  
Codependency Level for Rural Nurses (n = 97)

	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>p</u>
Between	2.247	3	0.749	2.876	0.040
Within	23.957	92	0.260		

## CHAPTER IV

### SUMMARY, CONCLUSIONS AND DISCUSSION

#### Summary

The purpose of this study was to examine the role of environmental work stressors and family-of-origin dysfunction in the genesis of professional codependency and compare rural and urban samples of nurses using those parameters. The nursing literature presents two contradictory explanations of the relation between codependency and nursing. Some see it emerge when a nurse's wish to care for others is motivated by attempts to fulfill her or his own unmet needs from dysfunctional family experience. Others see the medical institutional expectation of devotion and self-sacrifice by nurses as a causal factor in codependency. Both interpretations are based on the predication that there is a high prevalence of codependency among nurses.

A third factor, population density, specifically highly urban verses highly rural practice, may be tied to codependency in that rural nursing is theoretically different. Rural nursing may be defined by generalist practice, role diffusion and lack of anonymity. Study of rural nursing practice provides evidence that relationships among the members of the rural community make it especially difficult to distinguish between personal and professional roles.

This study was guided by to the underlying principles of Field Theory. This theory is broad and encompasses several concepts: system, field, matter and force. Presently, systems are seen as families and as health care institutions; fields as relationships, emotions, patterns of living and understanding; matter as people and the physical environment; and force as the energy used to exert influence, disequilibrium or polarization within conscious or subconscious environment.

This descriptive research study surveyed registered nurses who work in an acute care setting in either rural North Dakota or metropolitan Minneapolis, Minnesota. The sample was made up of 99 urban and 103 rural nurses who returned surveys to determine their codependency level, the presence of family traits associated with codependency and characteristics of their workplace.

The Friel Codependency Inventory, a 60-item-true-false self-assessment, provided a score which then placed participants in a category from few codependency concerns to severe codependency. Perceived workplace stress was evaluated by the modified Ward Organizational Features Scale. The tool consists of 30 questions which rate perceptions of environmental factors that may be stressful to the individual in the areas of professional practice, professional relationships and unit management. Five questions about the participant's family life which have been previously linked to codependency provided data regarding family-of-origin dysfunction.



The rural and urban samples were statistically compared to the codependency categories using a Chi-square test. No statistically significant differences were found. The second research question was tested using analysis of variance comparing the codependency categories to the mean organizational features score. Those with few to mild codependency concerns had less perceived workplace stress than those with severe codependency concerns. Analysis of Variance was also calculated to determine that there was not a statistically significant relationship between codependency and family-of-origin dysfunction. When controlled for population density, only the main effect, a relationship between codependency and perceived workplace stress was noted.

### Discussion

When compared to other studies of codependency among nurses reported in the literature, this study detected a somewhat larger percentage of nurses with moderate to severe codependency concerns. Holder, Farnsworth and Wells (1994) studied 91 nursing students to determine what percentage presented a history of being reared in a dysfunctional family and demonstrated codependency traits. The majority of traits fell in the mild to moderate range with only 17% in the moderate to severe and severe categories. Chappelle and Sorrentino(1993) used Roy's adaptation model to examine the levels of codependency within one nursing environment ( $n = 160$ ). Thirteen percent reported moderate to severe levels of codependency. King and Miracle (1992)

studied the prevalence of codependency in 142 critical care nurses in tertiary care hospitals. The mean score on the Friel Codependency Assessment in their sample was 29.28 (SD =11.9) which reflected mild to moderate codependency. One hundred fifteen home health and hospital nurses were surveyed by Yates and McDaniel (1994) and only 25 percent were found to have moderate to severe codependency traits. All studies used the Friel Codependency Assessment Inventory as the data collection instrument. The present study found 30.6% of acute care registered nurses to have moderate to severe or severe codependency concerns.

Although a number of studies indicate that rural nursing *practice* may differ somewhat from urban nursing practice (Long and Weinert, 1989), very limited ethnographic and survey data has been collected about *rural nurses* as individuals and how the dimension of ruralness affects them as individuals. Perhaps unique characteristics of urban practice affect nurses in a similar manner as the distinctive features found in rural settings when compared for codependency traits.

The failure to find urban-rural differences in codependency traits may be due in part to comparable socioeconomic, ethnic, historical and cultural diversity that affects risk for substance use and family dysfunction. The drama of individual lives, including achievements and behavioral dysfunctions, is played out against the backdrop of these important social, economic and cultural variations.



The finding that dysfunction in the family-of-origin was not related to codependency in this study is surprising. Much clinical evidence and a number of empirical studies identify, both among spouses and children of alcoholics and other habitual dysfunctions, patterns of behavior and family roles that were conditioned by the addictive or abusive behavior of another family member. (Biering, 1998). Several hypotheses can be advanced to account for this negative finding. First, this study is somewhat limited by the measure of codependency utilized. Using a retrospective self-administered instrument may present limitations in terms of the depth and accuracy of findings. Fifteen of the respondents (7.5%) noted on their returned questionnaires that the "yes"-"no" format and some items that contained double negatives on the Friel Inventory were confusing to them.

There is also a definite lack of consensus among authors on the conceptual and operational definitions of codependency. For example, Wright and Wright (1991) view codependency as a relational style that a person may use in some, but not all, relationships, and suggest measuring codependency with respect to a specific relationship. The Friel Codependency Assessment Inventory is based on the theory of arrested identity development defined and advanced by Whitfield (1987). Different measures of codependency (reflecting different conceptualization of the construct; e.g., Fischer J. L., 1991; Roehling & Gaumond, 1990; Potter-Efron & Potter-Efron, 1989) might yield substantially different patterns of findings. Thus one should be cautious in generalizing from



the operationalization employed in the current study to alternative conceptualizations, especially those of a more interpersonal nature.

Second, the usefulness of the codependency construct has not gone unquestioned. Gierymski and Williams (1986) challenged the concept of codependency as a stereotype of spouses of alcoholics similar to that stereotype of alcoholics, who once were believed to be derelicts and society's "drop-outs". These authors voice skepticism with regard to the concept because of a comparison of Minnesota Multiphasic Personality Inventory (MMPI) scores of wives of alcoholics and nonalcoholics which revealed no significant differences. Mallory and Berkery (1993) and Yates and McDaniel (1994) point out that many behaviors and roles that have been labeled as codependent are strikingly similar to roles and behaviors traditionally associated with womanhood in general. Other authors and researchers challenge the construct validity of codependency on the grounds that it is not diagnostic and only represents a description of highly diverse symptoms (Anderson, 1994; Carson & Baker, 1994; Gorski, 1990; Haaken, 1990; Harper & Capdevila, 1990).

Third, adult children of substance abusers may be attracted to caring professions such as nursing without necessarily displaying the symptoms of codependency. Biering (1998) studied how professionally competent nurses experienced and understood the link between their childhood adaptation to dysfunctional families and their personal and professional growth. He found that the coping skills they learned to survive in their families later became tools to

develop personal maturity. Anderson (1994) and Carlson-Catalano (1992), noted that some codependents moved from despair to action by increasing self-efficacy, developing consciousness of how problems emerge, reducing self-blame and assuming personal responsibility for change. Thus, they were able to experience intimacy and maintain autonomy in relationships using what their dysfunctional family upbringing taught them "not to do".

The finding that there is elevated level codependency as perception of workplace stress increases is consistent with the beliefs of many authors on the subject. Cullen (1995) identified four forces that contribute to the stressful conditions under which nurses work: (a) The health care system through its multiple regulations, reimbursement issues, and mandates; (b) the institutional system by short-staffing, mandatory overtime, insufficient equipment, and being put in the position of having to lower nursing standards to accommodate employer's financial agendas; (c) the social system through it's flawed sense of what constitutes positive outcomes; and (d) the nursing system by presenting as "normal" the kinds of situations most people would find uncomfortable.

Joinson (1992) labeled codependency in the helping professions as "compassion fatigue" and argues that although some stress is inherent in every job and in every nursing environment and is not always bad, the additional pressures in the current health care system have created a new set of demands that push nurses to the extreme. Cullen (1995) calls the health care system a "toxic environment" referring to the external organizational forces that determine



the conditions under which nurses work. Arnold (1990) states hospitals are like "phantom families" and can be as dysfunctional--creating systems to meet their own needs. Klebanoff (1994) describes codependency as a set of survival skills for living in an oppressed subculture and names it "internalized oppression". Whatever the labels, the core issues are that: (a) Nurses perform a number of roles but the essential product they deliver is themselves; (b) human need is infinite; and (c) the health care system's goal of high quality at low cost pushes nurses to give more of themselves to deliver the product efficiently.

Roberts (1983) observed that nurses exhibit the same "oppressed group behavior" as colonized Africans, Hispanic-Americans, African-Americans and Jews in Nazi Germany. This syndrome appears when one group is controlled by another group that it perceives as having more power and influence. Oppression leads to certain behavior patterns in the less-powerful group, including low self esteem and burnout, which, according to Roberts, are seen in nursing.

Building on Roberts research, Klebanoff (1994) observed that the patterns of codependency and the patterns of internalized oppression of women as nurses are very similar. She concludes that the essential practice of nursing--as well as its position in the power structure of the techno-medical-industrial complex constitutes "a serious occupational hazard for nursing as a profession and for nurses as individuals" (p. 151). One of the respondents to the questionnaire in the present study wrote a letter which very eloquently describes



her experience as a nurse in an oppressed work environment:

As the years passed [being a nurse] and I moved from novice to expert, I started to reflect on the energy of the new grads. What had happened to my energy? When did I become a cynic? I always saw myself as a role model for the newer, fresher crew. I allowed them to see my bad, unproductive behaviors and how I processed my problems and solutions.

I started feeling oppressed by the system--my energy was going toward fighting the system instead of where I wanted it to go--helping the newer faces and caring for my patients. I tried for a little while to get into the system (administration), to try and work with the powers. Then our large university got bought out by a private company. All the work and progress we had achieved got dumped almost overnight. The Buck became the bottom line. I went back to the bedside, but the expectations and work load got heavier. It got to the point where I, as a seasoned, experienced RN, got scared every day before I came to work. Some days were OK; many more days were extremely dangerous. I was no longer able to be a mentor; I was fighting to be safe. The quality of the learning process for the new grads deteriorated. Morale, well, there wasn't any. . . . I fell into the traps of co-dependency many times along the way of my career. Not for want of not working on myself, but pushed into it from the system itself.

Some contend (Covello, 1991; Joinson, 1992) that the entire nursing profession shows strong codependency traits because nurses are trying to achieve professional satisfaction in a dysfunctional health care system. Just as a codependent child "covers" for her parent, making excuses and concealing abusive behavior, nurses go along with dangerously low levels of care due to increasing acuity and chronic understaffing. The codependent child "feels the fate of the family rests in her hands alone" while in nursing "similar feelings render the nurse unable to delegate tasks, hire ancillary staff and take on non-nursing duties that rightfully belong to other departments" (Covello, 1991, p. 132). Joinson agrees and adds, "Nurses convince themselves that coming in early or working an extra shift is to help co-workers. What they are really doing is buying a cheap self-satisfaction by perpetuating the illusion of good health care that really doesn't exist " (p. 118).

There have been few empirical studies to examine the relationship between health care system stressors and its impact on nurse's personal well-being. The association detected between codependency and organizational stressors in this study was made with a small sample (comparisons between 28 rural nurses with few codependency concerns who had an average score on the Ward organizational tool of 2.38 (SD = 0.49) and 9 rural nurses with severe codependency who scored 1.84 (SD = 0.41)). Again, caution must be exercised when making conclusions based on one study using self-report questionnaires.



Despite the limitations of this study and the dearth of research on the subject, the possibility that codependency exists and causes problems for nurses should not be dismissed. The observations and testimonials of many in the nursing profession provide strong support for the hypothesis that extreme workplace stressors are antecedent to a specific group of behaviors--need for perfection, fear of failure, the need to control the uncontrollable and an intense sense of responsibility. To dismiss codependency as a catch-all phrase with no empirical evidence and, therefore, of little benefit to nursing would be unfortunate. Clearly, more research needs to be done.

### Recommendations

#### Research

One of the tasks of researchers interested in the codependency concept is identifying its operations. Without operational definitions stated in behavioral terms codependency is impossible to document, evaluate, test and recognize in practice. The critics of the codependency construct have pointed out that there are a myriad of behavioral manifestations of codependency but no one clear operationalization based on a common conceptualization. Indeed, Whitfield (1991) identified 23 different conceptualizations of codependency from somatic disease to psychological disorders to a spiritual condition ("the shadow side of our love nature", p. 11).

Because a wide variety of common behaviors can be labeled codependent, there is a need for criteria that will determine when the behaviors



are so momentous as to be called a disorder. It is possible that codependency has characteristics that appear in normal people. In the case of a major loss such as death of a loved one, for example, denial is a common first response. This behavior is normal but becomes problematic only when it persists. The same is possible with codependency. Care taking and the need for control, for example, can become problematic when they command the interpersonal relationships of individuals.

Once construct validity and meaningful quantitative measures have been more clearly established, further propositions regarding codependency's relationships to other phenomena need to be tested using appropriate controls. Haaken (1990) argues that these axioms should only be tested within the context of broad based theory:

As clinical work has become increasingly guided by narrowly defined specialties on one hand, and by ad hoc eclecticism, such as co-dependency models, on the other, the potential for broad based theorizing is diminished. Research that is not anchored in broad based traditions backed by well-developed theories are tremendously vulnerable to clinical trends and popular literature that "pull it all together" conceptually. The co-dependence label becomes a broad conceptual container into which myriad life difficulties and internal and external pressures are placed. (p. 405)

Many in the addiction and psychology fields would agree that the codependency

concept assimilates far too much in attempting to offer one simple construct to explain the many factors that influence human emotional suffering. However, clinicians have found it compelling because it provides a diagnosis and a tool to understand what are really complex interpersonal relationships with multifactorial influences.

### Education

Stress is a major factor that must be confronted by all in the health care field. No one denies that many illnesses are directly related to prolonged stress. In the present study, nursing codependency has been linked to workplace stress--specifically those institutional factors which maintain the integrity of the health care system at the cost of individual needs. Yet few educators incorporate self-awareness or stress management into their curricular offerings (Holder, Farnsworth & Wells, 1994; Kowal, 1998).

Based on the conclusions of this study, there is a need to provide students with avenues for seeking self-awareness and self-help. Students and graduates must be made aware of how self-care and inversely, codependent behavior, can be associated with their professional role performance. Many nurses define themselves as care givers. When they omit the many other components of their personality and see themselves only in their professional roles, they may fall into codependency.

More importantly, students should be taught to recognize patterns of workplace stressors: Confrontations with the health care system are sapping



their enthusiasm and creativity; time is not allowed for nurturing their patients; their practice excellence has been replaced by financial and bureaucratic mandates; short staffing, overtime, voluminous paperwork, increased acuity and non-nursing duties are taxing their energy. Unless they acknowledge these pressures, and become aware of them as students, as mature nurses they may get further away from sensitivity to their own needs because they have learned to turn them off. A nurse in this situation may continue to try to meet the institution's, the patient's and his or her own needs. But though he or she works harder, no progress may be made because the institution's goals often run counter to the patient's and nurse's needs.

### Nursing Practice

Another task is to study whether (and how) codependency is related to holistic nursing practice, adaptation and coping, quality of nursing care and to further study how it is related to workplace factors. Holistic nursing practice implies that the nurse is concerned with the complete person--body, mind and spirit and that man is a biopsychosocial being. Pain, suffering and disease are universal to the human condition in all dimensions of its reality. How does codependency--viewed as a somatic disease, a psychological adaptation, an emotional response or spiritual sensation--fit into the model of holistic nursing? By dividing persons into desirable and intolerable attributes are they robbed of their wholeness? Are internal reactions and feelings and external forces and relationships



autonomous? These questions must be answered in the quest for holistic nursing practice.

With estimates as high as 60 to 80 percent of nursing students reporting abuse or chemical addictions in their families-of-origin it is imperative that the effect of this dysfunctional upbringing on their adult lives is studied (Holder, Farnsworth & Wells, 1994; Snow & Willard, 1989). Some addiction and psychology scholars argue that the responsible child is likely to become a nurse because he or she seeks relationships in which she or he is obligated to give care but not to receive it. In nursing these people continue to derive a sense of self-worth through caring for others or through achievement, as they did in their dysfunctional families (Hall & Wary, 1989; Holder, Farnsworth & Wells, 1994; Snow & Willard, 1989).

Biering (1998), based on his research of competent and well-adjusted nurses who grew up in dysfunctional homes, questions this hypothesis. He found that these nurses were able to use their distressful experiences for the good of themselves and others. Biering comments, "To transform into personal growth behaviors that were awakened by childhood distress contradicts the basic assumption Western psychiatry holds about mental suffering. Psychiatry does not expect the wound to promote growth, let alone to foster healing potentials" (p. 334). Nurses from dysfunctional families should then be encouraged to find and use new avenues for their old responses instead of getting rid of them.

Service (1990) states that, "When nurses begin focusing on themselves as individuals within a profession that is so other directed, so perfection and control oriented, and so requiring of personal sacrifice, the impact on patient care will be profound" (p. 7). Nurses must value themselves enough to believe that the system can be improved. They must work together to create a healthy workplace, one with adequate--and adequately paid--staff. One where nurses are given the time and the freedom to teach and nurture patients and families. One where nurses are rewarded for their ingenuity and creativity.

## APPENDICES



## APPENDIX A

### COVER LETTER

Dear Participant,

I am a graduate student in the College of Nursing at the University of North Dakota. There are currently immense changes taking place in health care in general and in the nursing profession in particular. To add to the understanding of the effect of stress and change on nurses and nursing I am conducting research on codependency levels among nurses. For this study codependency is defined as "a pattern of behaviors by a nurse that meets other's needs at the expense of her/his own". The literature contends that codependent characteristics may be fostered in the individual by professional nursing education, societal expectations, and workplace environment. The opposing view is that people are drawn to the profession because it perpetuates the roles they played in their families as they were growing up. Other research indicates there are differences in the social and professional environment between highly urban and highly rural settings. To study these variables this research will assess the difference in codependency scores between rural and urban nurses and if any differences can be related to work environment or to characteristics of the family-of-origin. To gather data about these variables, participants will be asked to fill out a questionnaire.

Your participation is very important to this study and is gratefully appreciated. No known risk is associated with participation. Your responses may provide significant insight into your current life situation and reflection on your nursing career. A scoring guide for the codependency assessment is included at the end of the questionnaire for your own information and use. You may withdraw from the study at any time without consequences.

The questionnaire will take less than 20 minutes to complete. Participation is voluntary and data are anonymous. This study is about nurses and is *not* an evaluation of specific individuals. Only aggregate data from the study will be published in the final report. Please do not make identifying marks on the questionnaire or return envelope. Completion of the survey and returning it to me indicates your agreement to participate.

If you choose to participate, please complete the survey and return it in the postage paid envelope provided. Further information regarding this research study may be addressed to: Nancy Carlson, P.O. Box 31, Tioga, ND 58852, or by phone at (701) 664-2298, or by e-mail at [dcarlson@nccr.com](mailto:dcarlson@nccr.com). Thank you for your time.

Nancy Carlson, Masters Candidate  
University of North Dakota, College of Nursing

Helen Melland, Thesis Chair  
College of Nursing, (701) 777-4525

## APPENDIX B

### FRIEL CODEPENDENCY ASSESSMENT INVENTORY

*Consider each question and answer "yes" or "no" in terms of how you generally feel.*

1. I make enough time to do things for myself each week.....Yes \_\_\_ No \_\_\_
2. I spend lots of time criticizing myself after an interaction with someone.....Yes \_\_\_ No \_\_\_
3. I would not be embarrassed if people knew certain things about me.....Yes \_\_\_ No \_\_\_
4. Sometimes I feel like I just waste a lot of time and don't get anywhere.....Yes \_\_\_ No \_\_\_
5. I take well enough care of myself.....Yes \_\_\_ No \_\_\_
6. It is usually best not to tell someone they bother you, it only causes fights and gets everyone upset.....Yes \_\_\_ No \_\_\_
7. I am happy about the way my family communicated when I was growing up.....Yes \_\_\_ No \_\_\_
8. Sometimes I don't know how I really feel.....Yes \_\_\_ No \_\_\_
9. I am very satisfied with my intimate love life.....Yes \_\_\_ No \_\_\_
10. I've been feeling tired lately.....Yes \_\_\_ No \_\_\_
11. When I was growing up, my family liked to talk openly about problems.....Yes \_\_\_ No \_\_\_
12. I often look happy when I am sad or angry.....Yes \_\_\_ No \_\_\_
13. I am satisfied with the number and kinds of relationships I have had in my life...Yes \_\_\_ No \_\_\_
14. Even if I had time and money to do it, I would feel very uncomfortable taking a vacation by myself.....Yes \_\_\_ No \_\_\_
15. I have enough help with everything that I must do every day.....Yes \_\_\_ No \_\_\_
16. I wish I could accomplish a lot more than I do.....Yes \_\_\_ No \_\_\_
17. My family taught me to express my feelings and affections openly when I was growing up.....Yes \_\_\_ No \_\_\_



18. It is hard for me to talk to someone in authority (boss, teachers, etc.)..Yes \_\_\_ No \_\_\_
19. When I am in a relationship that becomes too confusing and complicated,  
I have no trouble getting out of it.....Yes \_\_\_ No \_\_\_
20. I sometimes feel pretty confused about who I am and where I want to go with  
my life.....Yes \_\_\_ No \_\_\_
21. I am satisfied with the way that I take care of my own needs.....Yes \_\_\_ No \_\_\_
22. I am not satisfied with my career.....Yes \_\_\_ No \_\_\_
23. I usually handle my problems calmly and directly.....Yes \_\_\_ No \_\_\_
24. I hold back my feelings much of the time.....Yes \_\_\_ No \_\_\_
25. I don't feel like I'm "in a rut" very often.....Yes \_\_\_ No \_\_\_
26. I am not satisfied with my friendships.....Yes \_\_\_ No \_\_\_
27. When someone hurts my feelings or does something that I don't like, I have little  
difficulty telling them about it.....Yes \_\_\_ No \_\_\_
28. When a close friend or relative asks for my help more than I'd like, I usually  
say "yes" anyway.....Yes \_\_\_ No \_\_\_
29. I love to face new problems and am good at finding solutions to them.....Yes \_\_\_ No \_\_\_
30. I do not feel good about my childhood.....Yes \_\_\_ No \_\_\_
31. I am not concerned about my health a lot.....Yes \_\_\_ No \_\_\_
32. I often feel like no one really knows me.....Yes \_\_\_ No \_\_\_
33. I feel calm and peaceful most of the time.....Yes \_\_\_ No \_\_\_
34. I find it difficult to ask for what I want.....Yes \_\_\_ No \_\_\_
35. I don't let people take advantage of me more than I'd like.....Yes \_\_\_ No \_\_\_
36. I am dissatisfied with at least one of my relationships.....Yes \_\_\_ No \_\_\_
37. I make major decisions quite easily.....Yes \_\_\_ No \_\_\_
38. I don't trust myself in new situations as much as I'd like.....Yes \_\_\_ No \_\_\_
39. I am very good at knowing when to speak up, and when to go along with  
other's wishes.....Yes \_\_\_ No \_\_\_



40. I wish I had more time away from work.....Yes \_\_\_ No \_\_\_
41. I am as spontaneous as I'd like to be.....Yes \_\_\_ No \_\_\_
42. Being alone is a problem for me.....Yes \_\_\_ No \_\_\_
43. When someone is bothering me, I have no problem telling them so.....Yes \_\_\_ No \_\_\_
44. I often have so many thing going on at once that I'm really not doing justice  
to any one of them.....Yes \_\_\_ No \_\_\_
45. I am very comfortable letting others into my life and revealing the "real me" .....Yes \_\_\_ No \_\_\_
46. I apologize to others too much for what I do or say.....Yes \_\_\_ No \_\_\_
47. I have no problem telling people when I am angry with them.....Yes \_\_\_ No \_\_\_
48. There's so much to do and not enough time. Sometimes I'd like to leave it  
all behind.....Yes \_\_\_ No \_\_\_
49. I have few regrets about what I have done with my life.....Yes \_\_\_ No \_\_\_
50. I tend to think of others more than I do myself.....Yes \_\_\_ No \_\_\_
51. More often than not, my life has gone the way that I wanted it to.....Yes \_\_\_ No \_\_\_
52. People admire me because I'm so understanding of others, even when they  
say something that annoys me.....Yes \_\_\_ No \_\_\_
53. I am comfortable with my own sexuality.....Yes \_\_\_ No \_\_\_
54. I sometimes feel embarrassed by behaviors of those close to me.....Yes \_\_\_ No \_\_\_
55. The important people in my life know the "real me" and I am okay with them  
knowing.....Yes \_\_\_ No \_\_\_
56. I do my share of work, and often do quite a bit more.....Yes \_\_\_ No \_\_\_
57. I do not feel that everything would fall apart without my efforts and attention.....Yes \_\_\_ No \_\_\_
58. I do too much for other people and then wonder later why I did so.....Yes \_\_\_ No \_\_\_
59. I am happy about the way my family coped with problems when I was  
growing up.....Yes \_\_\_ No \_\_\_
60. I wish that I had more people to do things with.....Yes \_\_\_ No \_\_\_

*Demographic profile*

61. What is your age? \_\_\_\_\_ 62. How many years have you been a nurse? \_\_\_\_\_
63. How many years have you worked in your current position? \_\_\_\_\_
64. What is your marital status?.....Married \_\_ Single \_\_ Divorced \_\_
65. What is your gender?.....Male \_\_ Female \_\_
66. In your family are you the first child?.....Yes \_\_ No \_\_
67. When you were growing up did you have personal exposure to abuse of alcohol or drugs by a parent, sibling, grandparent or care giver?.....Yes \_\_ No \_\_
68. When you were growing up were you exposed to physical or emotional abuse of self, parent or sibling?.....Yes \_\_ No \_\_
69. How flexible was your family when you were growing up?.....Flexible \_\_ Rigid \_\_
70. What was the religious influence in your home when you were growing up?.....Strong \_\_ Moderate \_\_ Weak \_\_

Check Yourself! If you would like to know your codependency score, perform the following before you mail your completed questionnaire.

1. Use only questions 1-60.
2. Reverse your answers on the odd numbered questions. (Not on the questionnaire please!)
3. Add all the "yes" answers.
4. Score yourself:
  - <20 few codependent concerns
  - 21-30 mild to moderate codependency
  - 31-45 moderate to severe codependency
  - >45 severe codependency

## APPENDIX C

### WARD ORGANIZATIONAL FEATURES SCALE

Please rate the following in terms of your current work environment.

	<i>Strongly agree</i>	<i>Agree</i>	<i>Disagree</i>	<i>Strongly disagree</i>
71. Nurses actively support one another when trying out new ideas	4	3	2	1
72. Doctors are usually willing to take into account the convenience of nursing staff when planning their work	4	3	2	1
73. I feel nurses do not communicate with each other as well as they should	4	3	2	1
74. Nurses have a lot of influence making changes to clinical practice	4	3	2	1
75. There is a lot of unrest simmering under the surface at work	4	3	2	1
76. Disagreements with other health care professionals go unresolved	4	3	2	1
77. Nurses and medical staff share similar ideas about how to treat patients and families	4	3	2	1
78. Nurses on my unit show a lot of respect for each other	4	3	2	1
79. The medical staff do not ask for nurse's opinions	4	3	2	1
80. All the nurses on my unit pull their weight	4	3	2	1
81. Nurses at my work place are clique	4	3	2	1
82. Our nurse/patient allocation system works well for the type of patients we have on my unit	4	3	2	1
83. Nurses try out new approaches to care	4	3	2	1
84. Nursing staff can be bitchy towards each other	4	3	2	1
85. Other health care professionals ignore the convenience of the nursing staff when planning their work	4	3	2	1



86. We have a good understanding with doctors about our respective responsibilities	4	3	2	1
87. There are enough permanent nurses where I work to give a good standard of care to all our patients.	4	3	2	1
88. Nurses allow themselves to be at the beck and call of doctors	4	3	2	1
89. Nurses are always willing to help each other get through their work	4	3	2	1
90. Medical staff co-operate with the way we organize nursing	4	3	2	1
91. Paper work seems to be a priority here	4	3	2	1
92. Decisions are made democratically by nurses on my unit	4	3	2	1
93. Doctors are willing to discuss nursing issues	4	3	2	1
94. Nurses live in fear of making mistakes	4	3	2	1
95. Patient treatment and care are not adequately discussed between physicians and nurses	4	3	2	1
96. Auxiliaries and assistants give most of the hands on care here	4	3	2	1
97. Nurses are encouraged to reach their full potential	4	3	2	1
98. Medical staff are willing to co-operate with new nursing practice	4	3	2	1
99. We have a good understanding with other health care professionals about our respective responsibilities	4	3	2	1
100. Nurses have a lot of influence making changes in unit management and administrative procedures	4	3	2	1

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